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ABSTRACT

Current research in psychotherapy is indicted because: (1) it omits the question of social or political values; and (2) it fails to come to grips with the fact that social, political and economic institutions are a large part of the problems of those who need help the most. Poverty is defined in psychological terms as a pattern of hopelessness and helplessness, of feeling limited and expendable. In these terms, psychotherapy is viewed as excluding the old, the black, the poor and the ignorant. Given the absence of hard data supporting the effectiveness of psychotherapy with these individuals, a case is made for the use of non-prfessionals in mental health efforts which could serve this unserved population. In line with this, it is proposed that psychotherapy must couple individual remediation with attempts at institutional change. A residential youth center, formed by the author and a group of non-professionals in New Haven's ghettos, is offered as an example. Twenty youngsters, aged 16-21, previously adjudged to have almost insurmountable problems, were admitted. A control group was used. Results showed increased work attendance, increased incomes, and decreased arrests and time in jail. Also, the group came to feel less alienated and more trustful than the control group. (TL)

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Psychotherapy and the Psychotherapist:

The Non-Professional as Clinician - Change Agent*

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I. Introduction

There is little need, at least at this point in time, to review extensively that catalog of horrors which currently constitutes both the content and status of research in psychotherapy. What is really interesting to note however, is the fact that the absence of affirmative data -- be that data compelling or not -- has neither discouraged people from wishing to become psychotherapists nor prevented the mental health professions from establishing elaborate criteria concerning who may or may not qualify and be recognized as a psychotherapist.

The purpose of this paper is several fold. Attention will be focused on:

1. The attempt to present a brief (and unoriginal) rational for understanding at least in part, why research in the area of psychotherapy has been such a troublesome enterprise;
2. A brief discussion of the relationship between poverty and existing psycholgical treatment modalities;
3. An analysis of the role (or the lack thereof) of the non-professional in the mental health guild;
4. The formulation of a clinical perspective and role in which individual remediation is coupled with institutional change as part of the ongoing therapeutic intervention; and
5. Some data gathered from a setting in which non-professionals were given the total clinical responsibility for working with so-called "hard core" youth (i.e., adolescents who had not benefitted from previous encounters with established and traditional agencies, including the mental health professions).

Our goals are relatively simple and clear. They are: first, to add fuel to the continuing controversy surrounding both the role and relevance of psychotherapy and psychotherapists in a society characterized by acute social change; and second, to provide some value-oriented dimensions which might serve, at

least preliminarily, as categories and/or criteria for future research in the area.

II. Toward Understanding the Disasterous State of Affairs of Research in Psychotherapy

It would, I think, be little short of the truth to state that existing research in the area of psychotherapy has yielded data, the quality and scope of which is quite incommensurate with the efforts devoted to that scientific enterprise. In short, our labors have yielded the obvious and the absurd --- hardly gratifying rewards for what have been huge investments of time, energy and money.

We know, for example, that psychotherapy, independent of the practioner's theoretical predilection, is more effective with the rich as opposed to the poor, the white as opposed to the black, the young as opposed to the aged, and the educated as opposed to the ignorant. Indeed, we feel with empirical certainty that psychological treatment is more likely to succeed with those who are living in contrast with those who have departed from this vale of tears.

It goes without saying that the impact of the "one/third - one/third - one/third" studies has been dulled by subsequent attempts to both discredit the alarming implications of those findings and to find new justifications for continuing to do what our hearts and previous training compel us to do rather than what our minds might offer as alternatives. But, as Rubinstein and Parloff (1959) have indicted, even in those instances in which psychotherapy appears to be helpful, "basic problems of this field of research have remained essentially unchanged and unresolved, (for) there is no simple, reassuring, authoritative principle which clearly supports one approach and demonstrates the invalidity of the others"(P.292).

In part, I think that much of the difficulty surrounding attempts to do research, particularly outcome research, in the area of psychotherapy is related to the tacit agreement among both practitioners and investigators to omit or consciously subordinate the question of values (social, political or other) from evaluative criteria. Indeed, we have shied away from the issue

of values, seeing them as "intrusive" or "imperialistic" dangers in the supposedly non-judgmental situation we call psychotherapy. A second problem, one which I will elaborate upon in the next section of this paper, has to do with the fact that psychotherapy is predicated on the assumption that all people in need of help are dealing with personal issues of a "self-actualizing" nature (i.e., problems of transcendence, the "full flowering on one's creative potential", or genitality). In point of fact, as Reiff (1966) has indicated, those in need of help the most are people dealing with problems of "self-determination" (i.e., problems of negotiating with and changing essentially dehumanizing social, political and economic institutions), people for whom the question of survival, in the most immediate and catastrophic sense, takes precedence over psychological needs to luxuriate in the "idea of the sublime."

III. Poverty and Psychotherapy

I have often asked myself what the poor (both white and black), the addicted, the schizophrenic, and the psychopathic have in common that makes them such "poor risks" for the psychotherapeutic enterprise; poor risks, that is, compared to the mild-to-moderately neurotic patient who is usually white, relatively solvent financially, and fairly well-educated. In short, I have often wondered why psychotherapy is most effective with those who, both in number and objective reality, need help the least.

The answer is as illuminating as it is painful. Put simply and generally it is this: both the philosophical assumptions underlying psychotherapy as well as the demand characteristics of the psychotherapeutic situation itself are of such a nature as to exclude those who do not percieve themselves as having a stake in, concern for, and place within the existing institutiional matrix that passes for contemporary American society. For purposes of illustration I shall focus attention on the relationship between the poor and psychotherapy; but it should be understood that I view the situation as analogous for many of the other groups mentioned above.

Elsewhere (Goldenberg; 1966, 1970) I have attempted to define poverty in psychological rather than economic terms. I have found it to be a pattern of hopelessness and helplessness; a view of oneself as static, limited, and irredeemably expendable; in short, a condition of being in which one's past and future meet in the present --- and go no further. Little surprise, therefore, that the poor do not benefit from the "sustained talking cure." For them, and quite rightly so, the demand characteristics of the psychotherapeutic situation (e.g. its uncompromising faith in the power of words as mediators for behavioral change; its unwavering commitment to punctuality and continuity) are irrelevant and inappropriate. The disenfranchised black or poor white is, in fact, alienated, isolated, and insulated from the very society of which he nominally remains a member -- and no amount of psycho-dynamic gymnastics will ever convince or seduce him into feeling or believing otherwise for very long.

IV. The Non-Professional and the Mental Health Establishment

Given the above, and recognizing the fact that for the most-part psychotherapists, either for reasons of personal choice or professional training, have been singularly unsuccessful, unable or uninterested in modifying their own conceptual orthodoxy in order to engage themselves with the disenfranchised, the question arises as to the role of the non-professional in programs currently operating under the aegis of the "Community Mental Health" movement. It is, I think, in many ways a "political" problem, for, in the absence of hard data supporting the effectiveness of psychotherapy with the poor, it becomes difficult for us professionals to justify our control over the criteria which, in turn, regulate the flow of people through the turnstiles and on into the mental health guild.

In the case of the non-professional, for example, we are confronted with someone whose "credentials" are certainly very different from our own. In addition to not having gone through and survived the kinds of educational and training experiences that we have, he is usually someone whose background and, at times, problems are not

too dissimilar from the clients who, by law, we now have to serve. The fact many believe (Shlien; 1962), and that there is some data to suggest, that the ability to do effective psychotherapy is unrelated to formal education or training in psychodynamic theory, but is, rather, related to such human dimensions as honesty, courage and empathy, seems to make little difference in how non-professionals are "used" (and I employ the term advisedly) in the new mental health game. As Reiff (1966) puts it: "They become nothing more than wardens and nursemaids tending the mentally ill who are waiting for the professional to serve them. They become a garbage heap where the professional dumps the patients he feels he can do nothing for. And, finally, they can become the menial who performs all the 'dirty work' that the professional resents and wishes he could get rid of so that he could have more time to do the same old things" (P. 546).

Having thus denied non-professionals full membership in the mental health guild, elaborate rationales have had to be developed to justify their exclusion. Iverson (1965), writing with reference to the War On Poverty, offers one such rationale. He puts it in the following way:

> "The untrained worker, because of his need to achieve quick, tangible successes, may settle for short-range goals in affecting changes in behavior. It is important, however, in working with the non-professional, to encourage as many immediate successes as possible, especially in the beginning stages of his work. Another problem for the non-professional worker is becoming too emotionally involved and overly identified with the problems of the poor. It is well to point out some dangers which need to be considered in the hiring of such persons. The following are worth note:
>
> 1. Because of his success motivation, the untrained worker may be impatient with, or misunderstand a person's right to self-direction and decision.
>
> 2. The untrained person may not be able to listen. In his eagerness to deliver services, he may ignore the facts, feelings, and attitudes necessary to provide appropriate help. The need to tell people what to do about their problems is an urgent one to non-professionals, and they may become frustrated with persons who do not respond.
>
> 3. All too quickly the non-professional will give the illusion of being trained and will take on the mannerisms of the professional. (P. 12 - 13)."

Now, if the point being made is that there are potentially "good" and "bad" non-professionals, or that non-professionals need to learn certain psychological skills, or even that non-professionals should have further training, well and good. But implicit in many of the descriptions of the non-professional -- and even more explicit in some of the "cautions" that have been expressed with respect to what the non-professional can or cannot (really, should or should not) be allowed to do -- is the notion that when it comes to the non-professional, disconfirming data to the contrary, we are dealing with a very different kind of animal than, for example, when we are discussing the professional. What is most intriguing about the points raised by Iverson is that if one erased the word "non-professional" from his statement and replaced it with the term "psychiatric resident" or "clinical psychology intern" the meaning and implications of his statement would assume a different perspective and be seen in a different context. Anyone who has ever supervised the work of prospective clinicians has had to deal with exactly the same problems that supposedly "characterize" the non-professional. In other words, problems of "becoming too personally involved", affecting "the mannerisms and the language of the professional", and "the need to achieve quick, tangible successes" are not problems particular to non-professionals: they are issues that confront anyone who is embarking on a career in the area of human service. However, given the fact that Iverson's view is fairly representative of the field as a whole, what follows is a predictable and self-fulfilling prophesy: the non-professional is viewed as "innately" different from (and less worthy than) the professional and is given the kind of training (if he is trained at all) which is often a watered down version of what has already failed in the past. The result, of course, is that the world has been kept safe for the professional.[1]

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[1]The above should not be interpreted as a blanket or romantic defense of the inherent folk-wisdom of the non-professional. My work in the community during the past six years has convinced me that there are as many incompetent and destructive non-professionals as there are professionals.

V. A Clinical Perspective: The Coupling of Individual Remediation With Attempts at Institutional Change

At this point, I must confess that I see little hope of future research in the area of psychotheraphy turning out to be much better than previous explorations. And the reason is fairly simple: what is needed is not increased methodological sophistication -- Lord knows we have already spent far too much time and effort trying to emulate the empirical precision of our experimental colleagues hotly in pursuit of the Holy Grail called Science. Neither need we prostrate ourselves on the alter of introspection and "individual differences", seductive though that may be, and regale ourselves with the infinite quality of the human experience.

What I think is needed is a different conception, definition of and commitment to those very aspects of psychotherapy which have heretofore been viewed with suspicion if not downright contempt. By this I mean a commitment to action, engagement or whatever we wish to call the process by which we join another human being to consciously share our mutual incompleteness, examine critically its sources, and begin to do something about it in the world we must both inhabit. For indeed, psychotherapy is the very thing we have stripped it of: it is passion and values, morality and advocacy, courage and honesty. It is, in short, that special relationship which enables two people or a small group of people to form an alliance, an alliance whose goal it is to change the human condition not only in an office for 50 minutes at a time, but in the world where institutional arrangements and their constraints on personal freedom and self-determination influence, all too often in a manner that is counterproductive, the quality of life that characterizes our day and age. In summary, what I propose is that there is no such thing as psychotherapy unless and until we couple individual remediation with attempts at institutional change. I offer one such example.

VI. The Residential Youth Center

In 1966, I, together with a group of so-called non-professionals from New Haven's ghettos, developed what was called the Residential Youth Center (RYC). With funds from the U.S. Department of Labor, we were mandated to develop a neighborhood-based residential facility for youngsters (males) between the ages of 16 and 21 who were both out-of-work. The purpose of the project was several-fold, but two of its specific goals were: First, to evaluate the degree to which a residential facility, developed in and indigenous to the inner-city, could be utilized to facilitate the individual and collective growth of chronically poor and disadvantaged adolescents and their families; and second, to explore the clinical and vocational potential of an indigenous, non-professional staff with respect to their competence in dealing with both the problems of psychological poverty and a population heretofore dealt with exclusively by professional personnel.[2]

When the RYC became operational, it admitted into residency those twenty youngsters independently judged to have the greatest problems and longest histories of social, vocational, educational, and personal failure. All of the youngsters had had previous and negative experiences with mental health professionals, had diagnoses ranging from mental subnormality through character disorder to schizophrenia, and had spent an average of 1.7 years of their young lives in a mental, correctional or training institution. An additional twenty boys with similar problems were placed in a Control Group. Both groups were tested, assessed, and interviewed on a host of variables involving both behavioral and attitudinal functioning. On the behavioral level we were most interested in work attendance patterns, average weekly income, and re-arrest and incarcerations records. On the attitudinal level the attempt was made to measure the youngster's feelings about himself

[2] For a more detailed description and analysis of the Residential Youth Center the reader is referred to Goldenberg; 1969, 1970.

in society, his feelings of alienation, authoritarianism (the degree to which he saw himself rather than "the world" as the author of his behavior), trust, and Machiavellianism (the degree to which he felt he could manipulate the social world). In other words, the research design -- a pre-post attitudinal and behavioral index of functioning design with stay at the RYC as the intervening experimental treatment -- was geared to assess not only what the youngsters were doing, but also how they felt about it and how they experienced themselves as people in a complex, changing and often incomprehensible world. Retesting of both groups was done nine months to one year after the program began, and follow-up testing was done another year later.

Let me summarize briefly the results. On the behavioral level, and compared to the Control Group, the RYC Group:

1. Increased its work attendance records 61.7%;
2. Increased its gross weekly income average 109%;
3. Decreased its arrests 71%, and
4. Decreased its comparative number of days in jail 138%.

On the attitudinal level, testing done prior to the opening of the Center indicated no statistically significant differences between the Control and RYC-bound Groups on the variables of feelings of alienation, authoritarianism, Machiavellianism, and trust. After one year, retesting indicated the following:

1. The Control Group youngsters felt more alienated while the RYC Group experienced itself as less alienated from the world of social, institutional, and interpersonal relations. The difference between the two groups was significant at the .01 level.

2. The differences between the two groups on feelings of authoritarianism was significant at the .05 level of confidence, the RYC Group having become less authoritarian in orientation.

3. There was no difference between the two groups on the Machiavellianism scale.

4. The Control Group experienced the world and people in it

> in a significantly less trusting manner. The difference between the two groups was significant at the .10 level of probability.

Follow-up studies indicated that the results obtained during the first year of the program were being maintained long after the boys had left the RYC.

Two things, of course, must be added. The first is that the RYC's staff of indigenous non-professionals was given, and assumed, the total clinical responsibility of working with the youngsters and their families. The second, is that the treatment model employed -- and I think we can properly call it psychotherapy -- bore little resemblance to the dispassionate, disinterested and disengaged behaviors that have become synonymous with orientations focusing on problems of libidinal control, Oedipal conflicts, and penis envy. The "treatment" offered was a passionate one, one concerned with the very real problems of racism, survival, and self-help; problems of how to negotiate and manipulate "the system" in non-self-defeating and self-humiliating ways; and problems of how finally, realistically, and responsibly to change that system.

VII. Summary

I have gone on too long and the time is short. Let me conclude by asking that this paper not be viewed as an indictment, but as a challenge to our creative potential. I should like to believe that we are in this profession because we are, after all, men of good will. For ourselves, our profession, as well as the abysmal state of our society, I must believe we are all very very tired of failing.

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